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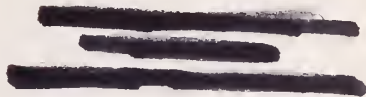

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SPRING 1967

The Journal of the Fort Logan Mental Health Center is a scientific quarterly which publishes original articles describing individual or collective modes of prevention, treatment, and related aspects of care for those persons with emotional disturbances. Emphasis is placed upon recording the investigation and description of those modalities broadly subsumed within the concepts of social and community psychiatry.

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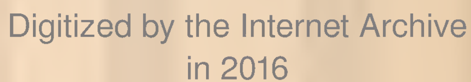

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THE SOCIOTHERAPEUTIC FUNCTION IN A
PSYCHIATRIC HOSPITAL.
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EDITOR'S NOTE

Dr. Marshall Edelson is Community Program Coordinator at the Austen Riggs Center and also is a faculty member of the Tavistock Institute's Conferences on Group Relations. Prior to his current position, he was on the faculty of the Department of Psychiatry at the University of Oklahoma.

Dr. Edelson's comprehensive paper on organizational behavior in a mental hospital setting is a distinguished contribution to psychiatric literature. It provides an important source of knowledge about the relatively unexplored area of intramural treatment as it reflects administrative and organizational processes. Because of the article's particular significance to the field of social psychiatry, the Journal of the Fort Logan Mental Health Center devotes this entire issue to its presentation.

S. B. S.

THE SOCIOTHERAPEUTIC FUNCTION IN A PSYCHIATRIC HOSPITAL*

MARSHALL EDELSON, M.D., PH.D.,**
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Austen Riggs Center, Incorporated, Stockbridge, Massachusetts

In this paper I wish to differentiate the sociotherapeutic function from other administrative and professional functions carried out in a psychiatric hospital organization.

I shall then use this differentiation in reviewing the variety of definitions of the so-called therapeutic community, offering finally a working definition that provides the basis for a consideration of the distinction between and the possible articulation of sociotherapy and psychotherapy.

I shall conclude by focusing upon the patient-staff meeting as a pivotal exercise in the therapeutic community. Such a meeting is an optimal setting in which to perform a sociotherapeutic rather than a psychotherapeutic function, since it is an arena in which the professional and administrative functions—previously differentiated theoretically in this paper and represented in the meeting by various groups in the hospital—interact, conflict, and are coordinated.

THE PSYCHIATRIC HOSPITAL: AN ORGANIZATION

Why therapeutic *community?* Is the hospital, in fact, a community? The word connotes likeness, concord—what is held or experienced in common. Emphasis is on the communality of interest all members share. Problems are thought to arise because members do not understand that their interests are the same. Through free and open discussion, for example, such problems, essentially related to misunderstandings, should disappear. A

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*The author wishes to acknowledge with gratitude the contributions of the late Robert P. Knight, Medical Director, Austen Riggs Center, Incorporated, Stockbridge, Massachusetts, who provided the opportunities, support, and encouragement that made this work possible; and Thomas F. Main, Medical Director, Cassel Hospital, Richmond, Surrey, England, who suggested the value of thinking about people in organizations.

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crucial question seems to be then: how can people communicate with each other and so join together in realization of their common interest?

But even a casual look at any psychiatric hospital exposes an astonishing variety of groups, points of view, and jobs to be done—many apparently incompatible or interfering with each other. The hospital is a veritable cauldron of conflicts, tensions, and apparent and concealed purposes—much more like an organism than a community. The question that actually must be asked is: in what ways can individuals and groups slug out their differences?*

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*Amitai Etzioni describes two approaches to conflict in industry, one emphasizing faulty human relations as the source of such conflict, the other attributing objective significance and a positive function to such conflict. The former frame of reference has been applied to mental hospitals, with the result that conflict tends to be attributed to misunderstanding brought about by lack of communication and its mitigation sought in increase of communication. That real differences in interest and opinion may be involved, that communication may only result in the drawing of clearer lines between individuals and groups and in an increase of tension, and that the resolution of difference depends on such organizational factors as the distribution of authority and power, tend to be overlooked. See: Etzioni, Amitai, "Interpersonal and Structural Factors in the Study of Mental Hospitals," Psychiatry, Vol. 23, pp. 13-22, 1960.

William H. Whyte, Jr. makes a similar point when he questions the assumption in the ideology of the modern corporation or of "group dynamics" as a social movement that the interests of the individual and the group are always in harmony and that an individual may find the fullfillment of all his significant needs by being a "good" group member. For a fuller discussion, see: Whyte, William H., The Organization Man, New York, Doubleday Anchor Books, 1956.

Conflict among administrative and professional groups and between the instrumental goals of the hospital and the requirements for the maintenance of the hospital, and competition between the needs of different functions within the hospital or the competition between groups to perform high prestige functions, are discussed, for example in: Smith, Harvey and Levinson, Daniel, "The Major Aims and Organizational Characteristics of Mental Hospitals," in The Patient and the Mental Hospital, Milton Greenblatt, et al., eds., Glencoe, Illinois, The Free Press, 1957, pp. 3-8.

These and other sources of strain in the mental hospital are also discussed in the same volume by Loeb, Martin and Smith, Harvey, "Relationships Among Occupational Groupings within the Mental Hospital," pp. 9-19.

Organization implies complexity, organic structure, interdependent parts—each having a special separate function but also each of whose relation to any other being to a large extent governed by its relation to the whole. Organization is, in one sense, a way of defining the pathways and procedures by which different functions are coordinated and carried out and by which differences are resolved.

Community suggests a closed system, self-sufficient, with the emphasis on internal relations. The hospital, however, is an open system. Its organization is determined by and concerned with not only *internal* functions relating the parts of it to each other, but also *external* functions relating the hospital to the rest of society. Such functions are ordinarily the responsibility of an *administrative system* within the organization.

The purpose of the psychiatric hospital organization, its primary collective goal, is to cope with the consequences of emotional illness for the individual patient, for the patients as a social group, and (to some extent) for society. The hospital discharges this responsibility through services. Any particular hospital may be characterized by the priorities it assigns these services.

One such service is *custodial*: the physical care of patients within the hospital. Another is *protective*: the safeguarding of patients and others from the harm, physical or social, that patients might do to themselves or others. Still another is *socialization*: the education of patients in the direction of understanding and accepting social expectations, within the hospital and outside of it. A final service is *therapy*: the treatment of patients with the aim of recovery from emotional illness (22).

The organization of the hospital determines the norms, rules, or patterns within which its goal is pursued.

The *external functions* of such an organization relate it to the rest of society. These include: (a) the *legitimation* of the hospital—for example, through conformity to legal requirements, public relations activities, and appeals for support—so that it may operate in the community; (b) relations with such *recipients* of the hospital's services as referring physicians, community agencies, and the patients and their families—encompassing admission and discharge

procedures and determination of the need for service and the requirement of payment for it; (c) the *acquisition of facilities*, including financial resources, personnel, and physical facilities; and (d) the *integration* of the hospital into the larger community, through such mechanisms as: (i) the institution of *contract* with professional personnel that maintains standards of competency and training; (ii) the exercise of responsible *authority*—for example, in commitment procedures and medical decisions—that takes into account the membership of the patient in groups outside the hospital; and (iii) the acceptance of *universal standards* of good practice and conformity with general social standards of acceptable conduct (22).

The exercise of these functions is associated with a variety of intragroup and intergroup strains in the psychiatric hospital.

The administrative system must mediate effectively between the sources of financial supplies and professional parts of the organization. In order to justify the trust of society, the sources of financial resources, whether legislative bodies or private donors, must have some controls over the uses to which money is put. This situation alone, if no other did, would introduce a line of authority and responsibility in any psychiatric hospital organization.

In addition, the exercise of authority inevitably arises from the fact that the organization must, in order to carry out its functions, have some degree of control over the situation in which it performs them.

Professional personnel are deeply concerned with their own autonomy and suspicious of any control over their activities. At the same time they insist that the administrative system provide them with favorable opportunities for the exercise of their special professional skills.

The professional person is required for the performance of the hospital's services and for the evaluation of such services, of the competency of those who perform them and of the adequacy of the conditions under which they are given. But the administrative system is also required to provide and safeguard the organization that makes possible an adequate setting for the performance of professional functions.

Administrative and professional needs, requirements, responsibilities, and activities, therefore, not only have to be

coordinated, but when they are incompatible, in some way must be assigned different priorities. Organization determines how the conflicts and strains between these two systems are to be resolved.

Professional personnel, including physicians, psychologists, and nurses, are responsible not only to the hospital but to the professional group to which each belongs. Professional personnel must perform according to standards set by groups outside the hospital; it is always conceivable that these might conflict with expectations within the hospital. Any role definition at marked variance to that of the professional group to which a person belongs literally may be felt to unfit him for functioning in any other setting and is strongly resisted.

It is a fact also that promotion in a psychiatric hospital is usually limited to promotion within one's own professional group and that one can only go so far as one's group goes in the organization. Naturally, then, each group looks to its own superiors for supervision and direction. These conditions result in professional groups, whose individual members are strongly oriented to the values, activities, and ways of looking at things of their own group and are not always especially familiar with those of other professional groups.

Strains between professional groups under these circumstances are inevitable. The hospital organization must be designed to allow for and cope with such strains.

The administrative system is responsible for authorizing and enforcing measures implementing the organization's commitment to groups outside the hospital. In addition, since administration derives the sanction of its authority over professional personnel by virtue of the recognition of those circumstances making organization necessary, the administrative system—in order to win such sanction—must be able to provide facilities and to allocate authority and responsibility in such a way that it is possible for professional personnel to operate effectively. The administrative system is thus also responsible for *internal functions*, which relate parts of the organization to each other.

These include: (a) the *socialization* of members of the organization or the implementation of the value systems of the organization; (b) the *integration* of the organization by enlisting the

loyalty of personnel and, therefore, by considering and seeking the belief of personnel in the "rightness" of decisions; (c) the *maintenance and improvement of adequate facilities* providing a base for professional performance; and (d) the *allocation of authority and responsibility* in such a way to ensure the opportunity for personnel to operate effectively (22).

The exercise of these functions also gives rise to and arises out of intra- and intergroup strains in the psychiatric hospital.

Housekeeping and dietary activities are examples of areas that are sources of conflict between administrative and professional groups in the organization, since the way in which housing and eating are arranged has great significance for the effectiveness with which the psychiatric hospital accomplishes its goal.

Recognition must be given to the special skills of professional personnel, to the protection of their integrity and autonomy, and to their ultimate responsibility for the policy decisions involved in carrying out professional activities. Such recognition may be attempted by sharpening the distinction between administrative and professional questions to ensure that professional personnel are consulted in cases involving the latter. It may also be attempted by blurring the distinction between administrative and professional parts of the organization and involving at least some members of the professional staff in the process of making administrative decisions.

The allocation of authority and responsibility can be a positive enabling function of administration, not often associated with authority by those who fear "authoritarianism." Any part of the organization must be protected by such allocation from undue interference from other parts in the performance of its function. That is, its relative autonomy must be safeguarded. A decision necessary to carry out a responsibility must be protected from overt or covert veto by individuals or groups not bearing the consequences of or not accountable for the decision.

Ultimately, the confidence of professional personnel in administration and their support of administrative decisions depend upon their knowledge that administration is facilitating successful achievement. Such confidence is related to awareness that adminis-

trative decisions occur in such a way that they take into account the varying consequences of any decision for different parts of the organization and the relative burdens and rewards accruing to these different parts as a result of such decisions. This confidence is also related to the administration's recognition of and deference to the professional staff in their capacity as responsible and expert members of their professional group, irrespective of their particular positions in the hospital organization.

A similar analysis may be made of the functions of professional personnel.

The *psychotherapeutic function* theoretically should be concerned primarily with the study and alteration of intrapersonal events, that is, events occurring within the patient. Essentially, this function is aimed at the resolution of *intrapersonal* tensions through the use of specialized techniques. Individual psychotherapy and group psychotherapy are examples of such techniques.

In *individual psychotherapy* manifestations of intrapersonal tension are studied in transference and resistance phenomena appearing in the relationship between psychotherapist and patient. Such intrapersonal tensions are resolved through a process of discovery and didactic explanation—the latter denoting the presence of verbal communication from one possessing specialized skills and knowledge.

In *group psychotherapy* manifestations of intrapersonal tension are studied in the group process—in shared group transference and resistance reactions appearing in the relationship among group members and between group members and the group psychotherapist. Similarly, such intrapersonal tensions are resolved through a process of discovery and didactic explanation.

I would like to suggest that theoretically the unique *nursing function* in a psychiatric hospital should be concerned primarily with interpersonal events—that is, events occurring between patients in their life together—and with the resolution of *interpersonal* tensions through the use of specialized techniques. (Such techniques are not so well known as the ones used by the psychotherapist.)

The psychiatric nurse qua psychiatric nurse, in addition to her usual nursing functions, should uniquely care for not so much

the individual patient as the *relationship* between patients. For example, rather than nurse an individual patient, she might help patients care for each other. (The result is that she finds herself nurturing healthy resources within patients rather than responding only to deficiencies or disturbances.)*

I would like to suggest further that the *sociotherapeutic function* in a psychiatric hospital should be concerned primarily with intragroup and intergroup events–that is, events occurring within and between various patient and staff groups–and with the resolution of *intra-* and *intergroup* tensions, through the use of specialized techniques again not so well known.**

The sociotherapeutic function is concerned with the discovery and explanation of those intra- and intergroup tensions interfering with the performance and coordination of professional and administrative functions. It is also concerned with the discovery and explanation of those factors interfering with and those mechanisms facilitating the resolution of such tensions.

The *activities program function* in a psychiatric hospital should be concerned with the interaction between patients (usually as persons expressing a particular group of needs or having or learning some special skills) and what are ordinarily (but not always) nonpersonal classes of events and objects, such as: the subject matter of a class; the media of the crafts shop; recreational events; special projects, such as a garden, greenhouse, library or nursery school; drama, music, or other interest groups.

This class of events and objects has to do with that sector of personality concerned with "interests" or "play;" it does not carry the connotation of obligation and "serious-consequences-if-not-done," which work, for example, does.

In a broad sense, one may say here that the activities program function involves the resolution of tensions between a patient or group of patients and a particular activity.

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*From a formulation made by Thomas F. Main, in a personal communication describing Cassel Hospital.

**Sociotherapy is called the didactic resolution of interpersonal tension states by Rapoport, Robert in "Oscillations and Sociotherapy," Human Relations, Vol. 9, pp. 357-375, 1956.

The *work program function* should be concerned with the interaction—or, in different terms, with the resolution of tension—between patients (as workers with competencies and obligations) and the task to be performed. Housekeeping, dietary, and maintenance jobs are examples. Ideally, the task is one of the kind that every patient is expected to perform and obviously necessary for the everyday life of the patients as a group. The failure to perform such work has immediate and unplesant consequences for the worker and his peers. Thus, although an element of obligation is always part of work, the ego in relation to reality, and *not* simply superego considerations, should be the subject of analysis and concern in group discussions of the interaction between patient and work.

A *research function* should contribute the formulation of relevant hypotheses and means for collecting data to test such hypotheses to the ongoing problem-solving in the hospital.

A *social work function* should be concerned with the relation between the individual patient and groups outside the hospital (for example, the patient's family or a community agency) and thus may be particularly concerned with the resolution of intrafamily tensions so that the patient may be integrated with his family.

Included under professional functions, there is also a *patient function*, because in the psychiatric hospital organization the patient is an employee.

The patient is not only a *customer* for the hospital's services, but—since the patient's cooperation and his social interaction are required for these services to be provided effectively—an *employee* of the hospital as well. The patient then must not only pay but *be paid* for his participation—by the approval of others, by realistic gains in his own life in the hospital, or by privileges and the absence of deprivation.

Since the patient's disturbance is not confined to one aspect of his personality, it is not possible to have him make a circumscribed job commitment to the hospital, as is possible with other employees. The hospital requires and must court the patient's generalized commitment to it, so that he is ready to pursue any problems that arise—and upon whose working out his therapy depends—wherever they may lead.

The patient's job should not have to do with "being sick." It should be rather to discover, express, and represent himself in all situations, and to maintain whatever healthy resources he has against encroachment by psychiatric illness.

He is an essential ally of the hospital in the production of custodial, protective, socialization, and therapy services, as well as their consumer.

He should, as much as possible, indicate his needs and the needs of his group, so that these may be identified and met within the limits of the hospital's resources and value systems.

He should, as much as possible, control and contain impulses within himself and others in his group, the expression of which would be contrary to his or their own interest or the safety of others, so that the hospital organization is not required to use protective mechanisms beyond its resources or violating its value systems.

The patient should struggle with—rather than passively comply with or blindly rebel against—the expectations not only of other groups and the larger community outside the hospital but of his own peers within the hospital as well. Then, in his interaction with the group and society his own identity and integrity are not lost or maimed, but rather discovered and established.

He should observe and report what transpires within himself and between himself and others, so that such information may contribute to the resolution of intrapersonal, interpersonal, and intragroup and intergroup tensions.

He should, as much as possible, participate in work and activities, thereby maintaining and adding to his own resources, so that he is able to be an adequate ally in the therapeutic endeavor, as well as a contributing member in the life of his own group.

If a patient performs these patient functions as a member of the hospital organization, he will maintain and enhance intact areas of ego functioning, and the regressive effects of illness and of hospitalization itself may be counteracted (9,34,38).

There are also *professional support functions*, which are concerned with providing help to personnel carrying out administrative and professional functions.

Education and training are support functions, concerned with the relation of various staff groups to an existing body of

knowledge and skills.

Research is another support function, concerned with the relation of staff members to a yet-to-be-acquired body of knowledge.

Personnel (psychiatric residents, for example) require education and training that are not necessarily relevant to their present position in the hospital and that are judged by the standards of groups outside the hospital. The knowledge obtained by research activities may be useful for the current problem-solving of the organization, but it also may not be. These are additional examples of the consequences for the hospital organization of the membership of personnel in professional groups outside the hospital.

Psychodiagnosis is a support function, concerned with providing personnel performing administrative functions with information they require to do their jobs—for example, the selection of patients for treatment.

The *physician on duty* at nights and on the weekend (the so-called O.D. or Officer of the Day), in addition to his usual functions as a physician, performs a support function unique to his position in the psychiatric hospital. I would like to suggest that he uses the authority he possesses (not by virtue of his position in the hospital but as a member of the medical profession) to sanction decisions of the nurse in her performance of nursing functions.

The nurse may make a routine request of the O.D.—for example, for an "order" for sleeping medication or a laxative—or she may report a disturbance in a patient or in a group of patients. He may respond, not with a "medical order," but rather—performing a sociotherapeutic function—by attempting to understand with the nurse what tension exists within the patient or nurse group or between these two groups giving rise to the nurse's communication to him.

He might then use such understanding to support the nurse in performing her unique nursing function. Instead of doing something to an individual patient, for example, she might use, repair, or care for some relationship between patients. I submit that a similar process may be carried out whether or not custodial care, protection, socialization, or therapy are the services at issue.

A *counseling function* may support the individual patient in performing the patient function, just as a *supervision function* may

support the psychotherapist in performing the psychotherapeutic function.

Thus, the characteristics of a particular hospital organization are determined by: (a) what groups of personnel, including patients, of course, are responsible and to what degree each group is responsible for these various administrative and professional functions; and (b) how performance of these functions is coordinated—for example, how conflicts between them are resolved.

It should be clear from this account that an uneasy equilibrium and at least intermittent strains must exist in the relations among professional groups and between professional and administrative groups. Members of such groups may, for example, in reference to any particular problem or event, have quite different interests or points of view, be emphasizing different services, be competing for the same resources (personal or physical), or be creating conditions inimical to others' effective performance.

It is possible in defining a so-called therapeutic community to emphasize the personal qualities, the tact, sensitivity, forbearance, interpersonal skills, and general wisdom required of individuals in the organization to mitigate these strains. In that event, one must depend on such mechanisms as psychoanalysis, education, supervision, and selection to provide and maintain adequate personnel. However, there are some obvious limits in the influence and availability of such mechanisms for the usual organization, which in general would suffer considerably if it had to depend on the presence of individuals with extraordinary qualities or the absence of psychopathological ones.

On the other hand, one may assume that the nature of the organization itself determines the fate—the expression or lack of expression—of individual qualities in the everyday life of the hospital. One may ask then what qualities the organization itself must possess, irrespective of the individual psychopathology, eccentricity, or genius of its members, that might mitigate such strains (14,15).

DIFFERENT VIEWS: THE THERAPEUTIC COMMUNITY

This analysis of psychiatric hospital organization and the functions comprising it may help to order the bewildering variety of

definitions of the therapeutic community, or the therapeutic milieu, as it is also called (26,29,30,35).

Definitions of the therapeutic community, particularly those within a humanistic or moral tradition, have emphasized the priority assigned to socialization or therapy services over custodial and protective ones.

If the preference is given to providing the service of *socialization*, the therapeutic community is called a school for living; its goal—adjustment to social life and work conditions outside the hospital; its significant mechanism of socialization—the patients' own group standards and expectations. Such a hospital seeks to provide custodial and protective service through the exercise of socialization mechanisms; for example, patients are "managed" through a process of "acculturation" and "group pressure" (10, 16,21,39).

If the preference is given to providing the service of *therapy*, the therapeutic community is called a school for personality growth. The principle mechanism of treatment is likely to be psychoanalysis or psychoanalytic psychotherapy.

However, there are also thought to be mechanisms of treatment inherent in the patient's participation in the life of the community (1,2,9,27,33,34,36,37).

Some examples are: (a) the resolution of intrapersonal tensions as a result of the resolution of interpersonal and intergroup tensions not only in the hospital but also, for example, in the patient's family as it is brought into the treatment situation; (b) the development and strengthening of adaptive ego functions through the patient's participation in the problem-solving activities of the hospital and his collaboration in forming and changing the goals and values of the group, in choosing the methods by which goals are to be reached, and even in determining some of the structural characteristics of the hospital organization; (c) the development or modification of inner controls as a result of identification with the standards and values of the group; and (d) the development of hitherto undeveloped tendencies to interpersonal relations, in a setting where safeguards and a particular value system permit risk-taking and experimentation in relating to others.

Definitions of the therapeutic community have also been written from the point of view of different *professional functions.*

Those definitions emphasizing the *psychotherapeutic function* focus upon the role of the hospital in helping the psychotherapist and patient perform this function (3,7,9,19,20,28,31,32). Some examples follow.

(a) The patient becomes increasingly aware of his characterological difficulties (or way of life) as these are expressed in the everyday life of the hospital and he is confronted by the consequences of these difficulties for himself and others; he brings this awareness to his work with the psychotherapist.

(b) The hospital creates a "new reality" in which people do not get caught up in the patient's transference expectations, provocations, or attempts to live according to the pleasure principle.

(c) The hospital, by maintaining and enhancing the patient's healthy ego functions—for example, through his participation in activities and work programs—increases his ability to act as a participant-ally in psychotherapy.

(d) The hospital provides the psychotherapist with information about the patient's life over a twenty-four hour period, access to which he might not otherwise have.

(e) The hospital helps the patient to manage impulses and to meet unconscious needs that might otherwise disrupt psychotherapy.

(f) The hospital provides the patient with a world in microcosm in which he may try out in relative safety the new insights and perceptions learned in psychotherapy and test their validity in life outside the session iteslf.

Those definitions emphasizing what I have called the *nursing function* tend to see the therapeutic community in terms of the quality of the interpersonal transactions that are sought within it: intense, open, honest, humane, understanding, compassionate, responsive (rather than indifferent), personal (rather than impersonal), experimental (rather than defensive).*

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*Focusing on changing the quality of interpersonal transactions rather than the patient's personality or the institution itself is recommended in: Schwartz, Morris, "Patient Demands in a Mental Hospital Context," Psychiatry, Vol. 20, pp. 249-262, 1957.

Those definitions emphasizing what I have called the *activities program and work program functions* tend to see the therapeutic community as one in which patients struggle in their daily lives with real tasks and in which the conditions of their work and play together reproduce crucial elements of life in any society.*

Those definitions emphasizing what I have called the *sociotherapeutic function* have tended to see the patient as part of the psychiatric hospital organization, participating with staff groups in decision- and policy-making. Focus is either on the formal structure of the hospital and its consequences, or on the process of the resolution of interpersonal and intergroup tensions through information-sharing and didactic mechanisms (4,5,6,12,13,16,17,23, 24,25).

A fundamental hypothesis, implied or explicit in this latter group of definitions, is that the interpersonal relations between members of an organization are determined by the nature of its formal structure, which decides the limits within which, the extent to which, and the ways in which personal qualities will be permitted or encouraged to become manifest (8,11,14,15,18).

From this point of view, a therapeutic community often is considered synonymous with a democratic organization. This kind of democratic organization is typically characterized by equalitarianism—a "blurring" of status differentiations and "flattening" of hierarchical structure. (The most famous example is the therapeutic community described by Maxwell Jones and his associates at Belmont Hospital (16,24,25).) There is maximum communication between all members of the organization, and likewise maximum participation

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*This is one element considered in the more complicated formulations of such writers as: (a) Main, T.F., "The Hospital as a Therapeutic Institution, "Bulletin of the Menninger Clinic, Vol. 10, No. 3, May 1946; (b) Sivadon, Paul, "Technics of Sociotherapy," Symposium on Preventive and Social Psychiatry, Washington, D.C., Walter Reed Army Institute of Research, 1957, pp. 457-464; (c) Sivadon, Paul "Techniques of Sociotherapy," Psychiatry, Vol. 20, pp. 205-210, 1957; and (d) White, Robert, et al., "A Psychoanalytic Therapeutic Community," Current Psychiatric Therapy, Vol. 4, New York, Grune and Stratton, 1964, pp. 199-212.

in decision- and policy-making about all problems (administrative or therapeutic) by all members of the organization.

Some qualifications and uneasiness have been expressed by thoughtful advocates of the equalitarian organization.

For example, David Hamburg (12), in advocating the facilitation of communication between all groups and a broader participation in the decision-making process by patients and staff, has written:

> This is not to say that everyone should communicate with everyone else about everything that goes on, or that everyone participates in all decisions; the relevance of a given person to a particular decision must be considered in deciding whether he should participate in making it. This viewpoint does not mean that people with administrative responsibility "pass the buck" to those who are in no position to make the decision, nor does it mean an endless series of conferences in which there is much communication but no effective action.

Robert Rapoport (24), in commenting on the inevitability of status differences even in an equalitarian organization, admits that despite the effort at "blurring" such differences what at best is achieved is a "quasi-equalitarian" organization:

> The fact that these differences exist formally as inherent in the hospital system of which the Unit is a part is a precondition that the Unit cannot remove in its present circumstances, but that its staff tend to blur as much as possible in order to achieve a quasi-equalitarian mode of functioning.

The attempt to distribute responsibility and authority equally throughout the group may result in the following.

The multiple subordination of each member of the organization to all other members exposes everyone to a variety of directives, opinions, points of view, and theoretical positions. The effect may be not simply the enrichment of everyone's thinking but rather uncertainty and confusion about expectations, tension, indecision, and hesitation to act or think independently.

The blurring of roles makes unclear who is responsible for what. While it is true that role-blurring may diminish dependency upon authority and the exertion of undue influence by status-bearers and thus raise the general level of responsibility felt by everyone for everything, it is nevertheless also true that role-blurring may

be used to conceal who in particular should be held accountable for a specific situation. In addition, improvisation of roles, when roles are not clearly defined, may lead to covert and overt struggles, often disguised as ideological or "theoretical" differences.

The maximum overlapping of roles, with many individuals responsible for the performance of the same function, may lead not only to expansion of the range of competencies of any individual, but sometimes to much duplication of effort and to loss of one's pride in a unique and autonomous achievement for which one has specialized training and skills.

The holding of multiple roles by each individual—everyone being responsible for many jobs—may provide an opportunity to use one job to escape from another when responsibility for the latter becomes awkward, arouses anxiety, or involves unpleasantness. In addition, one role may require attitudes, points of view, actions, or interests that do not necessarily coincide with—and may even conflict with—what is required by another role. Inaction, a muddled presentation, inconsistent stance, or abrogation of one role for the sake of the other, may be the outcome.

Information in an equalitarian organization may be distributed according to "personal" rather than "organizational" criteria, according to idiosyncratic wishes and fears rather than task-requirements. In addition, there is no way of determining the relevance of any information for any individual's work; much time is spent talking, writing, and meeting to reach the ideal that everyone know everything. There may be no way to screen information adaptively, because an unequal distribution of information is sometimes feared as upsetting an equalitarian distribution of authority and power.

The purpose of democratic organization should not be to emasculate or to permit the abrogation of authority out of hostility, fear, or guilt. It should be rather to gain permission for the exercise of authority.

A democratic organization—through the use of such consultation mechanisms as the Community Meeting, described in this paper—should be one that makes possible as wide a base of consent as is needed to support the decisions of those who in making such decisions discharge their responsibilities.

SOCIOTHERAPY AND THE THERAPEUTIC COMMUNITY

The therapeutic community is a psychiatric hospital organization, the goal of which is to help patients and society—through the provision of specific services to them—deal with the consequences of emotional illness, and in which higher priorities are assigned to the provision of socialization and therapy services than to custodial and protective services.

In order to achieve its goal, such an organization must provide for and facilitate the didactic resolution of intrapersonal, interpersonal, and intergroup tensions.

The psychotherapeutic function is concerned specifically with the discovery, didactic explanation, and resolution of intrapersonal tensions.

The sociotherapeutic function is concerned specifically with the discovery, didactic explanation, and resolution of intragroup and intergroup tensions—arising from the inevitable conflict and competition between the values, interests, and needs associated with different administrative (external and internal) functions and professional (psychotherapeutic, nursing, sociotherapeutic, activities program, work program, patient, and support) functions, all of which must be performed in the same organization.

Such tensions, of course, interfere with the performance and coordination of administrative and professional functions (including the sociotherapeutic function) required for the achievement of the hospital's goal, and their continuous resolution is a prerequisite for such achievement.

The patient-staff meeting—or community meeting—is a medium in which the sociotherapeutic function may be performed, in the same sense that the individual or group psychotherapy session is a medium in which the psychotherapeutic function may be performed.

I do not believe we know much at this time about the interaction between these two functions, but I shall ask what seem to me are the important questions.

To what extent does the didactic resolution of interpersonal and intergroup tensions in the entire social system and in smaller networks of relationships result in significant change within the individual?

To what extent does didactic resolution of intrapersonal tensions result in significant change in interpersonal and intergroup relationships in the hospital?

To answer such questions, observations of intrapersonal, interpersonal, and intergroup events must be made and related to one another. Intragroup and intergroup events may be optimally observed as a first step, then, in the patient-staff, or community, meeting; its goals, ongoing processes, and its function—and relation to other groups—in the psychiatric hospital organization, will now be described.

THE COMMUNITY MEETING: A CONSULTATION MECHANISM

The Community Meeting, a patient-staff meeting, is a consultation mechanism in the psychiatric hospital organization. A consultation mechanism is a sine qua non of a democratic organization in which the widest possible base of support for decisions is sought. It provides the opportunity for those who are directly responsible for making any decision to consult with those who will be affected by it and whose support is required to implement it. In a meeting—the purpose of which is consultation—sharing information, opinions, suggestions, and reactions contributes to: (a) coordinating different parts of a task operation; (b) winning support for proposed actions; and (c) evaluating past actions and accomplishments for the sake of morale and future planning. In this kind of meeting, decisions are not made by the entire group; this differentiates it from the group decision-making meeting of the equalitarian organization.*

In the Community Meeting, the sociotherapeutic function—and *not* the psychotherapeutic function—is performed. It is in this respect like other organizational conferences serving a consultative rather than executive or decision-making function—for example, a total staff conference, an interdepartmental meeting, or coordinating committee; it is *not* a form of group therapy.

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*Elliot Jaques has discussed at some length the characteristics of the consultation mechanism and its crucial role in a democratic organization. See Jaques, Elliot, The Changing Culture of a Factory, New York, The Dryden Press, 1952.

Such a meeting provides for the *sharing of information* about everyday life in the hospital and the problems existing in that life *now*. The prototype question is: what happened over the weekend? Yesterday? Last night? Today?

As such information is shared, a cognitive map of what is going on in the hospital is constructed; pieces of the puzzle are put together.

Disconnected, isolated bits of experience are ordinarily the source of affective waves that sweep over the hospital when emotions—associated with speculations, rumors, misperceptions, and misinformation—spread from person to person and group to group, without the facts from which they are actually derived. In this meeting, these come together.

A design, a pattern of events emerges. Areas of difficulty and breakdown are identified. Competing actually or apparently incompatible interests, values, and points of view previously hidden or unclear, and groups in the hospital representing the administrative and professional functions previously differentiated, struggle with each other in the discussion. A typical statement is: "I can't do my job or perform the function for which I am responsible, because..."

The focus is upon the *reality* of the tasks confronting members of the organization and the *reality* of the relationships between them, rather than upon the fantasies shared by group members about these tasks and relationships; the fantasies are tested against this reality.

The strains and tensions between individuals, between an individual and a group, or between groups, are often what is at issue. Their identification is the basis for the *diagnosis* of the nature of barriers preventing the effective provision of services to which the organization is committed in order to achieve its goals.

The *resolution* of such strains and tensions typically depends upon the action of individuals and groups outside the Community Meeting, actions taken in part out of an understanding of what has transpired at the meeting.

Various groups or individuals who have responsibility in the hospital requiring them to make decisions and take actions may

then use the Community Meeting to win consent for these decisions from those who will participate in implementing them.

After a decision has been made and implemented, the consequences of it may later be reviewed in the Community Meeting by all those who have been affected.

The group may share, for example, in the recognition of a task well done that contributes to the achievement of the hospital's goals.

On the other hand, errors, mistakes, and failures may be examined for the sake of understanding and future planning. Members of the group—staff and patients—should learn how to do this without anxiety, without defensiveness, without self-righteous moralizing, and without punitiveness.

The Community Meeting should not perform an executive, decision-making, or action-taking function, nor should decisions of various executive, decision-making, or action-taking groups be subject to veto by it. Advice from an individual or group or from the total group to an individual or group having responsibility is always a recommendation, on the grounds that the one who carries the responsibility and is accountable for the consequences of any decision to implement it should have the authority to carry it out in his own way.

The decision-making, action-taking, executive groups in the community include not only groups such as the nursing staff, activities staff, and various administrative staffs but also patient-staff committees responsible for the activities program, the work program, and the policies, rules, and procedures governing patient life and patient-staff relationships in the hospital.

In addition, the patients, informally or formally, with or without staff members, on the basis of geographical location within the hospital, age, sex, sociometric, diagnostic, or other criteria, may be organized into small groups that might perform a nursing function—for example, carrying out discussions or actions to help improve the relationships between patients or between patients and nurses.

These groups, simply in doing their respective jobs, come into conflict with each other and are responsible, therefore, for the existence of the strains and tensions in the community that

become clear in the Community Meeting. But they are also responsible for making the adjustments necessary to resolve such strains and tensions through processes of bargaining, compromise, and mutual accommodation suggested by and explored in discussions in the Community Meeting.

A conflict between such action groups or functions—for example, between interests and values crucial for the performance of nursing, administrative, and activities functions with respect to a particular situation—may arise that is *not*, it becomes clear in discussion, a matter of misunderstanding or misinterpretation of each other or of hospital goals and policy. Rather, there is an actual, absolute incompatibility in the interests or values of individuals or groups carrying out their jobs in the hospital organization.

In such an event, an apparatus in the organization must exist to make possible a decision assigning priorities to the various interests involved in the conflict, in the light of the total hospital situation as well as its immediate and long-range goals. Such a decision might be made by the medical director, after appropriate consultation. The decision-making process must include recognition of the distribution of the rewards and burdens each group or individual must bear as a consequence of such decisions and involve rules of fairness in making them.

A Community Meeting of this kind, devoted to an ongoing discussion of current problems in the hospital community and to the attempt to understand and resolve these, emphasizes the use of ego functions in coping with the problems of everyday life in that community, rather than superego-like processes of automatic compliance with or defiance of authoritarian or group rules, standards, or expectations.

A daily confrontation with and consideration of the actual consequences intrinsically arising out of an act or event supersedes sanctions arbitrarily annexed to an act and imposed by others in order to prevent its occurrence. Rules, no matter whether formulated by administrative "authority figures" or by a peer group, are not regarded as permanent solutions to problems to be automatically complied with or defied, but rather as signals of potential problem areas implying the advisability of review

and consultation when "departures" from the norm are desired.

The resulting individualization and active learning far outweigh in value the certainty and efficiency that might be associated with impersonally, automatically applied rules and regulations, enforced by administrative or peer group sanctions.

Furthermore, the exercise, maintenance, and enhancement of ego functions concomitant with participation in such ego-oriented day-by-day problem-solving is a crucial characteristic of the therapeutic community in which ego-impaired patients are treated (9).

ORGANIZATION OF THE COMMUNITY MEETING

The Community Meeting should meet daily if it is to function as described above. Otherwise, momentum and continuity are lost. Emergencies become the sole concern. Those who are in trouble receive much attention, those struggling to perform well receive little. Problem-solving becomes a matter of coping with crises, with intensive pressure for immediate action.

Under these circumstances, the didactic aspect of the resolution of tensions is likely to be sacrificed, and with it the possibility of much learning. Instead of the exercise of ego functions—the painstaking collection of information, the formulation and verification of hypotheses, the anticipation of and preparation for difficulty as well as the analysis of its causes after it has occurred, the evaluation of the consequences of action—it is either impulsive discharge or superego recrimination that are likely to determine the nature of crisis resolution.

Who should attend the Community Meeting? In general, those who have some important function to perform in the hospital community and who *need to participate* in the Community Meeting to perform it effectively.

Therefore, those in the organization having major responsibility for some administrative or professional function—including the external and internal administrative functions and the professional functions (psychotherapeutic, nursing, sociotherapeutic, activities program, work program, and patient)—should attend.

If problem-solving is to be possible, these functions must be represented in the Community Meeting not arbitrarily but by those whose jobs require them to make use of the Community

Meeting if their jobs are to be done well. Such persons will therefore inevitably represent in any discussion a certain way of looking at things, value, or interest inherent in their role in the organization.

Since the responsibility for the patient function (viewing the patient as an employee) cannot be delegated, but is borne by each patient, and since each patient's participation (viewing the patient as a consumer) is required if he is to receive the services for which he has come to the hospital, all patients should attend.

All nurses should attend, because of their crucial role in the organization, which derives from their continuous intimate contact with patients in the hospital.

A sociotherapist, who utilizes the meeting to perform the sociotherapeutic function and who is therefore responsible for its conduct, should be present.

The activities program and work program functions should each be represented in the meeting by at least one staff person bearing major responsibility for each program, even if such responsibility is discharged primarily by working with a patient group. Other members of the activities staff, for example, may be invited to attend a particular meeting or decide to attend one when they have some business to transact in it. Otherwise, unless such staff can be trained to use and understand the Community Meeting for the performance of their jobs, they are apt to attend it as uneasy or bored observers or irresponsible participants.

In my experience, those who perform purely professional support functions (staff education and training, research, psychodiagnosis, supervision) and who operate with relatively little direct impact on the daily life of the hospital, especially the daily life of the patients, need not attend every meeting. They too may be invited to attend or decide to attend when there is some business requiring their presence in the Community Meeting.

Those physicians performing O.D. duty are exceptions to this, because of their intervention in the daily life of the hospital when there is trouble; for obvious reasons associated with the function they must perform on such occasions, they should attend the Community Meeting.

Likewise, a person carrying out research in relation to or for the therapeutic community itself, or a person learning about the therapeutic community as part of his training, should, of course, attend the Community Meeting.

An administrator or administrators, for example, the superintendent and/or the assistant to the medical director, and on occasion perhaps a representative from the business office, should be present in the Community Meeting to represent and safeguard internal and external administrative functions in relation to any situation or problem that comes up.

However, the medical director probably should not attend the meeting regularly in this capacity. If the medical director represents administrative interests, his great authority and prestige are likely to result in administrative interests being given the highest priority in every situation. However, a higher priority ocasionally may and should be given to other functions when these are in conflict with administrative functions. In an ideal organization, those representing nursing, activities program, or work program functions, for example, are free to fight for their own values and interests even when these compete with those of the administrative system.

I am not sure every psychotherapist qua psychotherapist should attend the Community Meeting, but this question has not been completely answered to everyone's satisfaction in any hospital I know having an extensive program of intensive individual psychotherapy as well as an extensive therapeutic community program.

The psychotherapist, by virtue of the values and procedures involved in his particular function vis-à-vis his individual patient, may sit at such a meeting only to observe. Passive participation of this kind usually leads to boredom and withdrawal. He may come irregularly. If his attendance is required, he is likely to begrudge the time involved. His training does not ordinarily prepare him for understanding or participating in an endeavor of this kind; he may not know—since theory lags in this area—how to make use of the Community Meeting to do his job more effectively with his individual patient, but certainly it is not by doing "individual therapy" in the Community Meeting. He may even fear that participation in such a meeting is incompatible with the satisfactory conduct of

individual psychotherapy, for example, by muddling, needlessly complicating, or otherwise altering the transference.

A squad of such uneasy observers imposes a heavy burden upon the group.

Most psychotherapists, however, also strongly want to influence the daily lives of the patients with whom they work. The psychotherapist is likely to think that, because of his training and his understanding of his patient, he is able to do this better than anyone else—any administrator, nurse, sociotherapist, or member of the activities or work program staff.

He may, then, seek to exert influence in the Community Meeting, usually by making "interpretations" of group process or individual neurosis. If many psychotherapists attend, many such interpretations—often on different levels and headed in different directions—may inundate the group and result in confusion or introspective intellectualization in place of coping with the reality of problems in the everyday life of the hospital. Such interventions interfere with the conduct of the meeting and the performance of the sociotherapeutic function in it. The difficulty is increased because the prestige of the psychotherapist in a hospital organization gives his "interpretations" a power that may be far beyond their appropriateness to this kind of meeting.

If the psychotherapist does not attend, he may become suspicious of the Community Meeting and its effect on his patients; the extent to which this reaction occurs depends in part on the degree of his confidence in the staff involved in the meeting.

Patients may interpret the psychotherapist's absence as lack of support for or opposition to the Community Meeting or the therapeutic community program.

A patient may play off the psychotherapist and other members of the hospital organization against each other. He reports to the psychotherapist how intrusive, unreasonable, and punitive others are—for example, in the Community Meeting—or how devastating, disruptive, and destructive exposure to discussions in such a meeting is to him.

Such pleas, on the other hand, as "my psychotherapist says," or, "I'm working it out in my individual therapy," act as barricades behind which the patient hides when dealing with the

expectations and problems of life in the hospital. He does not participate. He claims exemptions. He splits his transference reactions; he responds to the psychotherapist as "all good" and to the community program or aspects of it as "all bad"; or he complains of each to the other, concealing in so doing the actual hostility he feels toward the recipient of his confidences about the other (19).

It might be helpful to have someone, a director of psychotherapy perhaps, attend the Community Meeting prepared to represent the psychotherapeutic enterprise as such and to defend it from being encroached upon, interfered with, impaired, or undermined by other aspects of hospital life. He might also have responsibility for interpreting to other psychotherapists, who do not attend, events in the Community Meeting, as well as for discussing with other psychotherapists the nature of any individual patient's way of life in the therapeutic community and its possible meaning for psychotherapy.

THE SOCIOTHERAPIST

The sociotherapist should be responsible for understanding—and communicating such understanding to those with whom he consults—the consequences of intragroup and intergroup strains and tensions in the hospital.*

The sociotherapist in discharging his responsibilities in the Community Meeting helps to create the conditions in which the

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*For other discussions of the role of sociotherapist, or of the role of a research team involved with change in a social organization, or of the role of an individual with sociological or anthropological training in a psychiatric hospital organization, see: (a) Devereaux, George, "The Social Structure of the Hospital as a Factor in Total Therapy," American Journal of Orthopsychiatry, Vol. 19, pp. 492-500, 1949; (b) Greenblatt, Milton, "The Psychiatrist as Social System Clinician," in The Patient and the Mental Hospital Milton Greenblatt et al., eds., Glencoe, Ill., The Free Press, 1957, pp. 317-326; (c) Jaques, Elliot, "Some Principles of Organization of a Social Therapeutic Institution," Journal of Social Issues, Vol. 3. No. 2, pp. 4-10, 1947; (d) Jaques, Elliot, The Changing Culture of a Factory, New York, The Dryden Press, 1952; (e) Rice, A.K., The Enterprise and its Environment, London, Tavistock Publications, 1963; and (f) Sofer, Cyril, The Organization from Within, Chicago, Quadrangle Books, 1961.

Community Meeting can function as the consultation mechanism in the psychiatric hospital organization. To carry this out, it is his job to make interpretations about intergroup and group-individual relations; he may not be the only staff person making such interpretations, but he is the staff person in the meeting primarily *responsible* for making them.*

He should not make interpretations of individual neurosis, although of course he is aware of its manifestations in the Community Meeting. He should not analyze any individual's intrapersonal tensions or intrapsychic conflicts. He should not interpret phenomena in terms of an individual's transference relationship with his psychotherapist, although manifestations of this, too, may be obvious to him.

If he does any of these things, he is simply performing a psychotherapeutic function in a group setting. Such interpretations are not only irrelevant to and distracting from his performance of the sociotherapeutic function and the achievement of the goals of the Community Meeting, but they may also involve him in possible interference with the patient's psychotherapist.

It may be noted that patients in individual psychotherapy themselves like to make such interpretations and to see the Community Meeting as a form of psychotherapy—often as part of a resistance to coping with the problems of hospital life.

The sociotherapist should not make interpretations of the group process of the Community Meeting itself, although he will govern his own participation through understanding this group process. He should not interpret shared fantasies about events in the Community Meeting, about himself and group members' relationships with him, or about group members' relations with each other. In other words, he should not perform "therapy of the group," nor attempt to perform a psychotherapeutic function by using the Community Meeting as a form of group therapy.

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*For one attempt to differentiate levels of interpretation in individual psychotherapy, group therapy, and the community meeting, see discussion of "prototype interpretations" in Edelson, Marshall (9). With reference to the community meeting, Thomas F. Main contributed further clarification in personal communications resulting in the following formulation.

If he does, or if others are preoccupied with such interpretations, the group turns its eyes inward, and introspection about the Community Meeting itself rapidly replaces interest in—and may indeed also serve resistance to coping with—the problems of everyday life in the hospital.

There are exceptions to this proscription.

The sociotherapist may have to interpret group process in those circumstances in which other ways of coping with group process phenomena—which interfere with or act as resistances to problem-solving in the Community Meeting—have failed.

Ideally, he always connects any comment about group process with an inference about what is going on tn the life of the hospital. For example, group members' feelings about the sociotherapist and their ways of dealing with such feelings in the Community Meeting may be representative of what is happening in the relations between patients and members of the staff in the everyday life of the hospital.

The sociotherapist typically makes interpretations concerning those factors—in particular, intragroup and intergroup strains and tensions and those forces, assumptions, and values maintaining them—interfering with the adaptive problem-solving process, the performance and coordination of administrative and professional functions, that must go on if the services to which the hospital is committed as an organization are to be provided. The conflicts he interprets are not between intrapsychic institutions—between wishes and defenses, for example—but are between groups, or between functions that must be performed, in relation to a responsibility for achieving some task.

The sociotherapist cannot be responsible for suggesting ways of resolving such intragroup and intergroup tensions, only for helping the members of the group understand what stands in the way of the resolution of such tensions.

Decisions made or action taken to solve problems is the responsibility of the various groups and individuals comprising the Community Meeting, and suggestions for such adaptive decisions or actions ordinarily are made or responded to by those members of the meeting who are responsible for and must bear the consequences of them.

If the sociotherapist participates much in the making of decisions by patient-staff action groups outside the Community Meeting, he may become committed to or associated with a particular point of view or solution. This is likely to interfere with his being able to be or with his being seen as a person who, for example, is disinterestedly seeking that all points of view be represented in a discussion and then pointing out the tensions resulting from competing interests; the sociotherapist must have no special stake in one group or function winning such a competition at the expense of another.

THE COMMUNITY PROGRAM STAFF

The members of the staff who attend the Community Meeting are those who have some responsibility in the community program—the Community Program Staff. Members of this staff group should meet after each Community Meeting to advise and sustain each other and to accomplish the following tasks.

(a) The Community Program Staff must learn how to examine in its own meeting the contribution of each staff member to the Community Meeting. Each staff member attempts to answer the questions: How did I perform my job in the Community Meeting? What effect did my participation have upon the problems with which I am struggling in my job?

There are three kinds of difficulties any staff person may have in dealing with such questions: (i) organizational; (ii) personal; (iii) theoretical.

(i) Every kind of difficulty in the hospital *organization* will be reflected in difficulties in the participation of staff members in the Community Meeting: in silence, in confusion, in irresponsibility, in awkwardness and uncertainty.

If roles are blurred or overlap, if multiple subordination characterizes the role relationships of the organization, if an individual occupies multiple roles or shares a role with another, or if his authority is not commensurate with his responsibility, then we may expect consequences to appear in the Community Meeting.

The participation of staff members, of course, is crucial in its effect on the Community Meeting. The nature of that participation determines what problems will be brought up and to what extent

problems will be dealt with in the meeting and to what extent in less public, more covert ways. Staff members provide a model for patient members who will be quick to follow their cues and examples and who will be certain to exploit difficulties in staff relationships as these are manifested in the meeting.

A point of view or function may be missing from a Community Meeting for a variety of reasons: lack of role clarification; actual absence of an individual occupying a crucial role; the abrogation of responsibility to someone else when roles overlap; the abandonment of one role for the sake of another by an individual occupying multiple roles; the paralysis of an individual subordinate to more than one superior with conflicting expectations; the failure to act by an individual whose authority is not commensurate with his responsibility.

When a point of view or function is missing, its absence always wreaks havoc in the Community Meeting. Problem-solving cannot proceed or proceeds in error because of the absence of information, some important interest, or participation by someone who possesses authority and wields influence in the organization.

Almost inevitably, when a point of view or function is missing, someone without responsibility for a particular function rushes in, out of anxiety, good intentions, or discontent with his own role, to fill the vacuum. Since such participation is irresponsible (in a technical rather than moral sense), it adds further confusion, not only preventing real understanding of the factors at work in the problem being discussed but understanding of the very nature of the organization which must contribute to its solution.

Staff members participate most effectively in the Community Meeting when it is clear who is responsible for what. As on any good team the efforts of whose members are coordinated, everyone feels with respect and confidence that each other needed member of the staff will be present and doing his job competently.

In these circumstances, each staff member may turn his full attention and energy to his own responsibilities in the organization and to the representation in the Community Meeting of the interests, points of view, and values inherent in those responsibilities. Each staff member is then free to be a creative innovator

in the exercise of the function for which he is responsible in relation to any problem or situation that comes up for discussion.

In order to bring this about, the Community Program Staff must cope with organizational problems. It identifies them. It clarifies what—the changes in definition of roles, for example—might mitigate such difficulties. It communicates—for example, to the medical director or an executive body—recommendations for appropriate changes in the organization when these are necessary to mitigate such difficulties.

The following statements are typical of discussions revealing this kind of difficulty in the Community Program Staff Meeting.

"I didn't know it was my job to be concerned about that, to contribute that information, or to represent that point of view. No one ever told me I had particular responsibility in that area." In some organizations: "I thought it was everyone's responsibility to be worried about that." (Something that is everyone's responsibility is usually, in effect, no one's responsibility.)

"I know what I said had nothing at all to do with my job and might even result in Dr. Smith having a sticky situation on his hands; but Dr. Smith didn't say anything, and I was uncomfortable. I felt something just had to be said."

"Well, Mary is responsible for that too, and I was waiting for her to say something."

"I didn't know what to say at that point. As a nurse, I felt concerned about the relation between Jim and the group. I thought that some relaxation of the rule would be helpful to undercut Jim's effort always to cast himself in the part of the 'bad one.' But, on the other hand, I felt I had to fight to uphold the rule, even though that resulted in Jim's being driven further away from the group, because it is important administratively to have that rule and I felt it was also my job to argue for it." (Assigning both an administrative function and a nursing function to one individual may result in neither function being performed adequately—especially when each requires a stance or approach conflicting, competing, or incompatible with the other—or in one function simply being abrogated for the sake of the other.)

"I could not say anything. I thought Dr. Jones expected me to try to get that kind of solution considered, but if I did that, I

knew Mrs. Brown would be mad as a hornet."

"I knew when I didn't answer that question, it made everyone frustrated and suspicious about what was going on. But I don't have the authority to speak for the nursing staff. I felt I had to ask Mrs. Brown and the other nurses first."

(ii) A second kind of difficulty an individual may have in the Community Meeting is *personal.*

He may be having trouble integrating his role with his personality or resources.*

He may not know how to relate to others in a "human," relaxed, friendly, flexible way—feeling that would be somehow incompatible with the performance of his administrative or professional function.

On the other hand, an individual may have difficulty taking distance from those with whom he sympathizes, empathizes, or identifies, in order to use his understanding to discharge his administrative or professional responsibilities.

An individual may be overwhelmed by feelings so that he cannot behave professionally; on the other hand, his feelings may be completely unavailable to him so that his job performance is empty, impersonal, and ritualized.

An individual may also feel his job requires him to act in a way that is incompatible with his values or actual abilities.

Solutions to such problems depending on the stifling of spontaneity, enthusiasm, involvement, compassion, inventiveness, or openness (such as may occur in the rigidly hierarchical organization) are not adequate. Neither are those solutions depending on the abrogation of individual responsibility and authority (such as may occur in the equalitarian organization.)

Discussion of these problems in the Community Program Staff Meeting may help staff members to integrate better their personal and professional identities and to face the discharge of responsibility and the exercise of authority, even when this promises unpleasantness.

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*This point has been clarified by personal communications from the late Robert P. Knight, Medical Director, and Lars Borje Lofgren, staff psychiatrist, Austen Riggs Center, Stockbridge, Mass.

Occasionally, it becomes clear that someone is being expected to do a job he cannot do; in this connection, it is well to remember that the silence of staff members is determined by fears and wishes similar to those motivating the silence of patients: fear of one's job performance being exposed; fear of criticism and sanction; fear of those having authority; fear of the judgment of one's own subordinates; reluctance to give advantage to a competitor; or desire to make things awkward for a superior.

Typical statements expressing such personal difficulties in the discussions of the Community Program Staff Meeting are:

"I wanted to say something then, but I didn't know how."

"I didn't say anything when you asked who was on duty last night. I was so angry at Janice for the way she had acted, I figured she could just answer all the questions about what happened herself."

"It's not up to me to say what must be done. That's up to the whole group."

"Why should I raise that point? I'm just another member of the group. I want to be a human being in the meeting, not an authority figure."

"I didn't feel I could say anything about that. After all, I'm not a patient, and it was something that affects *their* lives we were talking about."

"I know it would help if I'd crack a joke once in a while, but I don't feel comfortable doing it."

"I have never done my job before in full view of everyone."

"I didn't think that problem should be brought up. Everyone would have gotten angry at me, and that would just make my job more difficult."

"I was afraid I'd be criticized; so I didn't say anything. I feel paralyzed in the meeting. I'm afraid *you* won't like what I'll say. (I'm afraid *he* won't like what I say. I'm afraid *they* won't like what I say.)"

(iii) Individuals may have difficulties participating in the Community Meeting because they misunderstand the *theoretical* rationale for its existence.

The most usual misunderstanding involves conceiving the meeting as a form of individual or group psychotherapy. It is con-

ceived to be group therapy for the patients, or a patients' meeting—rather than an organizational meeting in which many people, including patients, are required to participate in order to perform their jobs effectively.

The result may be a meeting whose sole function appears to be psychotherapeutic or nursing. Under these circumstances, staff members responsible for other functions become confused or apathetic about their own presence and participation in the meeting.

The psychotherapeutic model is adopted as a guide for behavior in the Community Meeting, despite its inappropriateness to the purpose of such a meeting. Taking care of the "sickest" patient, who is showing the most regressed behavior in one form or another, is then always assigned a higher priority than taking care of those individuals—staff or patients—who are functioning and attempting, but with difficulty, to do their jobs—including the patient job—in the hospital. The problems of the "workers" are set aside while the group organizes itself into a "*psychotherapist*"—with everyone questioning, analyzing, reassuring, and interpreting—and a "*sick patient*," who responds in one way or another to these ministrations.

(Members of small groups in the hospital might more appropriately have particular responsibility for their individual members and take care of each other, especially during periods of incapacity, distress, or crisis.)

Typical statements in the discussions of the Community Program Staff Meeting which suggest this kind of difficulty are:

"I thought that the group was trying to help Bill, and that was more important than the matter I wanted to see discussed."

"I was waiting for a patient to bring it up."

"I wanted to see what was on the patients' minds before I spoke."

"It's the patients' meeting, not our meeting."

(b) A second task for the Community Program Staff Meeting is to provide consultation for each staff member concerning the implications that experiences in the Community Meeting have for him in making decisions and taking action in his own area of responsibility and authority.

This is not different from those discussions about the implications of what has transpired in the Community Meeting being held for the same purpose in various patient-staff action groups—for example, having responsibility for the activities program, the work program, or the management of social problems. Discussion by staff members in the Community Program Staff Meeting about such implications helps them to clarify what is involved and needed—for the sake of their own subsequent participation in such action groups.

The head nurse may begin to plan with her staff what might be needed from the nurses over a weekend—with so many patients depressed, upset, and guilty about some situation in the hospital.

The head of the activities staff may plan how to help the teachers of classes in the activities program, as a result of her understanding of the attitudes of patients toward a "student" role—exemplified, not necessarily in a discussion about activities, but perhaps in one about feelings toward physicians-in-training.

(The staff person with responsibility for a certain function does not simply attend to what is going on in the Community Meeting when that particular area of responsibility is the explicit topic of concern. He is always asking: what is the implication of this discussion, no matter what it is about, for my job? How can I make a contribution to it from my own point of view and with my particular resources? The obvious example is when activities resources are suggested for coping with a nursing problem—to alleviate difficulties a member of the group might be having in relating to others.)

The head of the activities staff may also plan how to help the patient-staff group responsible for the activities program see that its job includes responding to *current* needs being expressed in the Community Meeting—for example, in complaints about the emptiness of weekends or difficult holiday periods.

The staff person having responsibility in the work program may think about the implications for that program of a discussion in the Community Meeting in which it became clear that the patient group must sabotage any plans to have fun over a holiday because "we don't do any real work; every day is a holiday for us. Other people take good care of us. We don't deserve a holiday."

He may also draw conclusions for needed action from a discussion in which it became clear that the multiple subordination of the maids and kitchen staff to the head nurse and to the superintendent of buildings and grounds was creating a barrier to resolving difficulties arising between patients doing housekeeping and dietary work and the maids and kitchen staff with whom they were thereby coming in contact.

An administrator may become convinced that the apparatuses of the hospital community available for dealing with a patient who is a "social problem" have been exhausted, that they are inadequate to deal with this particular kind of "social problem," that the safety and welfare of members of the group and the reputation and standing of the hospital are seriously jeopardized, and that he must therefore initiate procedures that might lead to the discharge of the patient in question.

Discussion in the Community Program Staff Meeting then involves trying to understand—through the Community Meeting itself, together with other information about aspects of hospital life available to different staff members—the current problems of that life, so that each staff member may subsequently use such understanding in discharging his own responsibilities.

(c) A third task of the Community Program Staff Meeting is—on the basis of its members' understanding of and participation in the community program, including the Community Meeting—to formulate recommendations to other units, groups, or individuals in the hospital: for example, to the medical director (change is needed in the organization, a decision is required to resolve the competing interests of two departments); to the director of psychotherapy (a review of the tangled relations among two patients and their two psychotherapists is needed); or to the Community Meeting (additional information is needed in the discussion of an issue currently before the Community Meeting).

(d) The Community Program Staff may attempt to study various problems and answer certain questions through a research arm as well as its own discussions.

What is the fate of problems that are brought up at the Community Meeting?

Are the steps of a problem-solving process different in

type or order of occurrence when an administrative function is involved than when a psychotherapeutic one is at issue? Do different professional functions require different problem-solving processes or procedures to deal with typical questions arising?

Are different contributions required from persons responsible for different functions: is a social-emotional contribution, distinguished from a task-oriented contribution, more appropriate to one than to another?

Are there some problems solvable by a process of discussion and consensus in the Community Meeting alone; are there others requiring more formal procedures of decision-making and implementation?

It should be apparent from this discussion that the Community Program Staff Meeting is not an executive body but a consultation mechanism to be used as such by the members of the Community Program Staff, and at times by others in the hospital organization in discharging their responsibilities through decision and action.

THE SLEEPING GIANT

We may regard the patients as a relatively informally structured "community" of interacting individuals who have a common residence (with all the ties, types of relationship, problems, and pleasures this implies), and the staff and the patients as a relatively formally structured "organization" of interacting individuals who work together to accomplish certain goals (with the roles, job differentiations, distribution of authority, and responsibilities this implies).

Then one problem is to integrate the interactions of the patient "community" with those of the patient-staff "organization"—in addition to that of integrating the various patient-staff and staff groups in the formal organization—so that there is one united effort and the treatment goals of the hospital are facilitated rather than obstructed.

The Community Meeting is one mechanism designed to facilitate such "integrations"—not then either a meeting of the patient community alone or of the patient-staff organization alone but a meeting in which the two come together (as well as a meeting in which the various patient-staff and staff groups in the formal organization come together).

Prototype topics, involving the integration of "community" and "organization," are the impact of drinking, sexual behavior, noise, recreation, sharing of chores, and efforts by patients to collaborate with nurses to help each other, on members of the community, on the formal organization, and ultimately on the achievement of the hospital's treatment goals.

Prototype topics, involving the integration of formal organization groups, are concerns with the coordination of, and cooperation and collaboration (or lack of it) between patient-staff committees responsible for government, work, and activities and staff groups responsible for administrative and professional functions—as well as the achievements (or lack of them) of these various groups in carrying out their tasks.

The view that a sociotherapeutic function can best be performed in the Community Meeting follows from an analysis of the hospital as an organization, oriented to the achievement of certain goals, and in which jobs or roles are differentiated in terms of the "best" way to achieve these goals. Inevitably, the performance of various jobs brings individuals and groups in the organization into conflict or competition with each other from time to time, thus resulting in strains in the organization. At the Community Meeting, such strains should be mitigated (the sociotherapeutic function) by their becoming apparent in the process of group discussion and through the clarification of what differences, conflicts, and competitions are involved and what some resolution of them might include.

An intellectual analysis of differences as these are revealed in the Community Meeting—getting the group to see such differences more clearly—does not by itself help to mitigate strains in the organization; in fact, if anything, under some circumstances, it appears to increase such strains. Some integrative resolution is the aim of the Community Meeting.

An ideal-typical problem-solving process might proceed through the following phases.*

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*For a discussion of these phases, see Parsons, Talcott; Shils, Edward; and Bales, Robert, Working Papers in the Theory of Action, New York, The Free Press of Glencoe, 1953.

I did not read this work until after the previous sections of this paper were completed, so that the presentation of the Community Meeting as involving a sociotherapeutic or integration function, while it is compatible with the Parsons' model, did not derive from it.

If we start with an adaptive phase, characterized by the attempt of group members to become oriented to the situation, then during such a phase cognitive activity, asking for and receiving orientation, asking for and receiving opinions, would be especially relevant and evident.

From such a phase the group might move into a goal-attainment phase. During this phase, suggestions (instrumental moves) for the actual attainment of a goal might predominate.

A basic hypothesis is that any movement in the hospital toward the actual attainment of a goal, that is, any task-orientation, inevitably results in strains between groups and individuals.

Such strains must be dealt with in the following phases, which are social-emotional in character rather than task-oriented.

The next phases would be integrative-expressive, in which showing agreement or disagreement, showing tension or releasing tension, and above all showing antagonism or solidarity, would predominate. The goal of such a phase would be to provide for tension-release and especially to increase the solidarity of the group as a prerequisite for entering a final phase in which the level of satisfaction rises to a point—and in which learning becomes consolidated to an extent—that the group is again ready to enter an adaptive phase.

From this point of view, the function of action groups in the community (for example, patient-staff committees responsible for government, work, and activities, as well as staff groups responsible for administrative and professional functions) may be viewed as primarily task-oriented and therefore as contributing to the adaptive and goal-attainment phases of problem-solving in the hospital organization.

However, the activity of such groups inevitably results in strains in the community or organization.

The function of the Community Meeting might be especially, although perhaps not exclusively, to provide a mechanism for carrying out the integrative-expressive phases. The emphasis in this meeting is not on adaptation or goal-attainment (activities directed to these functions might on occasion be opposed to the carrying out of an expressive-integrative function) but rather on tension-release for the individual (this may be also a particular

function of small groups in the hospital program) and the accomplishment of solidarity for the entire group (a unique function of the Community Meeting).

During an integrative-expressive phase, the Community Meeting would essentially attempt to re-establish the "boundaries" of the group—who we are as a group, what characterizes us, what differentiates us from other organizations, what values do we hold in common—in order to heal the strains or wounds that have resulted from moves toward task achievement in the previous phases, which have occurred typically (although not perhaps exclusively) outside the Community Meeting in action groups in the organization.

During such a meeting the emphasis should be on the identity of the group, its characteristics and possessions, the interests members have in common, and the existence of a generalized and durable affective attachment among the members of the group.

The ideal output for the Community Meeting—in addition then to a cognitive orientation to the situation—should be above all a sense of solidarity, a decrease in intergroup strains, perhaps some reduction of individual tension, and some consolidation of learning, leading ultimately to a return to adaptive and goal-attainment phases throughout the organization.

This would seem to suggest that staff members in the Community Meeting should be contributing to it not merely pressures toward adaptation, goal-attainment, action, or decision, which increase strains, but special attention to attempts to resolve the strains which have already resulted from such pressures in the organization: for example, mending fences, being helpful and rewarding, increasing feelings of status and self-esteem, and showing solidarity with other staff members or groups.

In addition, in such a meeting, the wants of members of the group make themselves known and initiate a process of problem-solving that may ultimately result in changes in the way of life of the entire organization.

In my experience, in the beginning neither staff nor patient members of a Community Meeting appreciate what an impact upon the hospital organization their discussions will have. They only dimly perceive and have little confidence in the power for change associated with reliance on a problem-solving process focused upon

current problems in a day-by-day reality (compared to that associated with reliance on tradition, constitution-making, or rules and procedures).

Then as the influence of the Community Meeting upon the life of the hospital becomes clear, members of the group—both staff and patients—begin to recognize the responsibilities that must inevitably be borne by those wielding such influence. They shrink back. There is fear of being overwhelmed with burdens. There is a panic-stricken rejection of those who would discuss their problems with others. There is staying away. There is silence.

But, inevitably, with the passing of time, with the efforts of those who continue to struggle and occasionally to succeed, with the shakings and alarms of one shared event after another—the Sleeping Giant awakens.

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The Fort Logan Mental Health Center is Colorado's second state hospital. Currently serving almost half the population of the state, its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with emphasis on expansion of professional roles and the involvement of the patient's family and his community in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. Approximately one-half of its patients are admitted directly to day care, and evening care is offered. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient from the time of admission through all phases of treatment.

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